MASTER CLASS

In-Office Surgery Can Boost Practice

BY CHARLES E. MILLER, M.D.

Given the constant threat of falling reimbursement, ob.gyns. throughout the country are exercising options on how to maintain a successful practice. For some, introducing new treatments has proved successful. We are all well aware of gynecologists who get involved in various aesthetic techniques and plastic procedures. However, for others, this option represents a marked departure from their practice profile.

It would appear that the introduction of in-office gynecologic surgery will offer many ob.gyns. the opportunity to add value to their practice, yet stay within the limits of the procedures they were trained to perform while in residency—that is, within an ob.gyn.'s "comfort zone."

A second advantage of in-office gynecologic surgery is that it allows the physician to maintain efficiency.

Let's face it: Operating rooms are fraught with delays. Performing surgery within the confines of the office allows the gynecologist to be free of the yoke of OR tardiness.

Finally, procedures may actually be compensated better in the office than in the operating room, whether that OR is in an outpatient surgery center or in a hospital. Examples are hysteroscopic tubal occlusion or endometrial ablation.

I have invited Dr. James B. Presthus, who is currently practicing gynecology at Minnesota Gynecology and Surgery in Edina, Minn., to lead this discussion on office-based surgery. Dr. Presthus is an active member of the American Association of Gynecologic Laparoscopists, the American Urogynecology Association, the International Pelvic Pain Society, and many other professional organizations. He is a clinical professor of obstetrics and gynecology at the University of Minnesota, Minneapolis. ■

DR. MILLER *is clinical associate professor at the University of Chicago and University of Illinois, Chicago, and president of the AAGL. He is a reproductive endocrinologist in private practice in Schaumburg, Ill., and Naperville, Ill., and is the medical editor of this column.*

Taking Gynecologic Procedures Out of the Hospital

BY JAMES B. PRESTHUS, M.D.

It is both easier and more important than ever to move more gynecologic procedures out of the hospital and into the office.

The levels of burnout in our specialty are increasing as too many of us—90% of the 42,000 ob.gyns in the United States—continue to pursue generalist careers.

We attempt to do it all, from primary care to obstetrics to surgery, and are being pulled in too many directions while losing any sense of control in our professional and personal lives.

There are alternatives to the model of being everything to every patient, however, and adopting office-based procedures can be a key component to making changes successfully.

Most of us perform in-office endometrial biopsies, colposcopy with biopsies, LEEP (loop electrosurgical excision procedures), and IUD insertions. Yet it is estimated that fewer than 30% of ob.gyns. do appreciable hysteroscopy in any setting, and fewer than 5%-10% do office hysteroscopy.

Many of us believe that office-based procedures are potentially dangerous and that they are painful and will not be tolerated by patients.

We argue against an increased level of office-based procedures on the premise that the equipment costs too much, the required skill level is too high, we don't see enough patients who are candidates for these procedures, we don't have procedure rooms, or the integration of more procedures into our existing schedules is just too complex or difficult.

Increasingly, these beliefs are countered by contrasting realities: more medical knowledge, more training opportunities, more reasonably priced equipment, and appropriate third-party reimbursement for office-based hysteroscopic procedures.

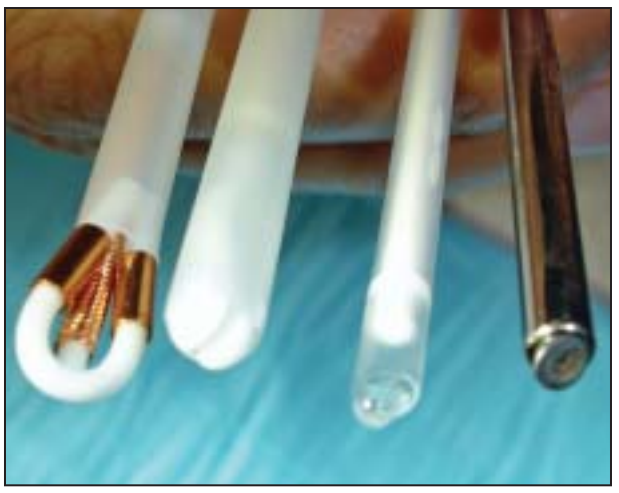
These realities have made hysteroscopy the base technology for a successful gynecology-focused office-based practice.

With commitment, those ob.gyns. who enjoy doing procedures can build successful office-based practices by offering a full spectrum of diagnostic and minor operative hysteroscopic procedures that are just as safe, tolerable, and effective as they are in the hospital.

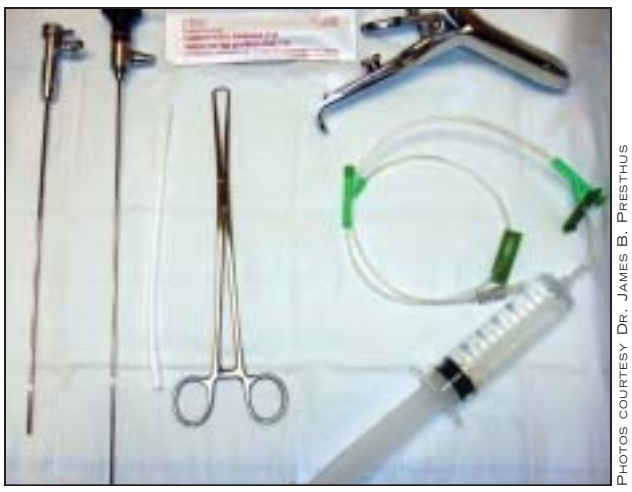
In doing so, they can provide more thorough and efficient care in a more comfortable, familiar, and cost-effective setting.

Less Anesthesia, More Accuracy

The most significant misconception among ob.gyns.—and probably the largest barrier to wider use of in-office hysteroscopy—relates to pain.



Diagnostic hysteroscopy with a small hysteroscope is less painful than an endometrial biopsy. Such a hysteroscope is smaller than an IUD (left).



A typical diagnostic hysteroscopy tray for in-office procedures includes a small hysteroscope and sheath, an os finder, and a single-tooth tenaculum.

PHOTOS COURTESY DR. JAMES B. PRESTHUS

The perceptions are fueled by the operating room experience, where intravenous sedation causes patients to lose inhibition and the ability to follow directions and control their actions.

Patients perceive touch and other stimuli as pain, and the loss of inhibition often escalates as the anesthesist applies even more IV sedation in an effort to make them more comfortable.

This is often perceived as intolerance for pain, and ob.gyns. leave the operating room thinking that if patients cannot tolerate hysteroscopy in that setting, they will certainly not tolerate it in the office.

In reality, patients can tolerate procedures very well—and with less anesthesia—if they know what to expect and if they're in control of their bodies and the overall situation. This happens more readily in the office environment, which is familiar, less intimidating, and more comfortable for patients.

In addition to the comfort that comes with familiarity, the office environment offers distractions that lessen the perception and feeling of pain, and the small-diameter hysteroscopes that are available to us today are no larger than a Pipelle curette and can usually be guided easily through the cervix without dilation, paracervical blocks, or the use of a tenaculum. A simple diagnostic hysteroscopy takes, on average, 5 minutes or less and is extremely well tolerated. It is less painful than an endometrial biopsy.

Patients are often interested in watching the video monitor during a hysteroscopic procedure. Their understanding and comfort level are greater when they can see the findings—can see in living color, for instance, what polyps, fibroids, or intrauterine adhesions are.

Of equal or more importance, hysteroscopy provides a focused view that has significant and measurable clinical benefits.

Ob.gyns. are more attuned to ultrasound; it's readily available, and the global view of the pelvis, uterus, and adnexa that it provides is often viewed as adequate. Saline infusion sonography has certainly improved diagnostic accuracy.

Hysteroscopy, however, offers a more focused view and gives us the ability to investigate and to do a targeted biopsy under direct vision. It simply provides for greater accuracy and more thorough care. Hysteroscopy should be viewed as complementary to ultrasound rather than as an alternative.

Hysteroscopy is the standard for evaluating abnormal uterine bleeding (AUB), a problem that affects more than 10 million women a year and is the reason for 25% of all gynecologic clinic visits.

Although endometrial biopsy is effective for diagnosing diffuse disease such as hyperplasia and carcinoma, it often misses focal lesions like endometrial polyps and fibroids, which are common causes of AUB.

Hysteroscopy should be considered in all patients who require an endometrial biopsy. It has been shown to have a sensitivity of 100% and a specificity of 95% in evaluating the uterine cavity.

It allows us both to diagnose more accurately and often to "see and treat" at the same time, avoiding the courses of unsuccessful hormonal therapy and multiple visits and procedures that too often result from a reliance on endometrial biopsy and ultrasound alone.

Office cystoscopy is a routine part of urologists' practice. With hysteroscopy, we have the technology and capability as ob.gyns. to similarly diagnose and treat common problems in a cost-effective, readily acceptable way. We must more seriously ask ourselves, why not?

Are our reasons not to embrace hysteroscopy really good enough?

Pages 24a—24b

Better Fits for a New Era

Ob.gyns. are often at a loss to explain why they seem to be working harder and harder while not getting anywhere, or while losing control, income, and/or the gratification of strong physician-patient relationships.

In a 2004 survey of approximately 830 District III ob.gyns., 64% reported symptoms of burnout; 16% wanted to quit medicine, and 40% said they planned to retire early. To maintain income or prevent a significant decrease in earnings, many had increased patient volume by 20%-30%.

Part of the challenge we face stems from declining reimbursement and the loss of entrepreneurship that often comes with larger group practices. But we also have an inefficient specialty. Many of us leave our offices for labor and delivery and for long OR cases that are unpredictable, that challenge the flow and efficiency of our office practices and the stability of our family lives, and that bring us reimbursement rates that do not account for waiting and time lost between cases. Often the reimbursement we receive when we are away from the office will not cover the cost of office overhead.

This is something we ought to analyze now. Depending on our professional interests, personal needs, and surgical and labor/delivery volumes, such a mix may be gratifying and completely acceptable, or it may be taxing, inefficient, and a cause of burnout.

An office-based ob.gyn. model of care can give us greater control of our practice, our scheduling, our patient relationships, and our lifestyle. Given the elimination of unproductive time, and the fact that professional fees remain the same regardless of setting and that facility fees go to the physician, we can also increase our reimbursement.

Substantial time and financial savings, moreover, are passed on to patients and payers. There is no wasted time: no separate office visits, for instance, for preoperative histories and physicals. When it comes to procedures, patients can arrive 10-30 minutes beforehand and leave in less than 30 minutes. In many cases a patient will be responsible for the cost of an office visit copay, compared with a large deductible and percentage of hospital costs.

I recently saw an interview with Warren Buffett in which he was asked why he is so successful in choosing investments. How was he able to predict the future? He replied that he could not predict the future, but he could recognize what was becoming obsolete. The era in which the model of care relied on a single ob.gyn. who could provide equally competent general primary care, obstetrical care, and the full spectrum of gynecologic surgery to the patient is rapidly becoming obsolete.

The specialty of ob.gyn. is destined to change. Many of us eventually will need to discover and carve out or fine-tune our roles. Today's generalist model of ob.gyn. will evolve into three components in the future: the office-based ob.gyn., the hospital laborist, and the pelvic surgeon.

Greatest in number will be the office-based ob.gyns. who provide well-woman primary care, office-based obstetrics (prenatal care), and a range of office-based procedures, from hysteroscopy and endometrial ablations to incontinence procedures, ultrasound, IUDs, cystoscopy, LEEP cones, and perhaps some "lifestyle" procedures such as laser hair reduction and varicose vein treatment. Considering the demand for such services, they likely will make up about 70% of the specialty.

The ability to have one office, fewer partners, no hospital responsibilities, and control over one's schedule can provide a career that is interesting and rewarding.

Ob.gyn. laborists will be modeled after internal medicine "hospitalists," and will handle routine deliveries and inpatient obstetrical management. The laborist will work a certain number of shifts each month and will have enough time to be able to balance his or her personal and professional life.

Pelvic surgeons will perform laparoscopy, operative hysteroscopy, and abdominal, vaginal, and robotic surgery. They will provide women with state-of-the-art surgical care and will not have to balance surgery with primary care.

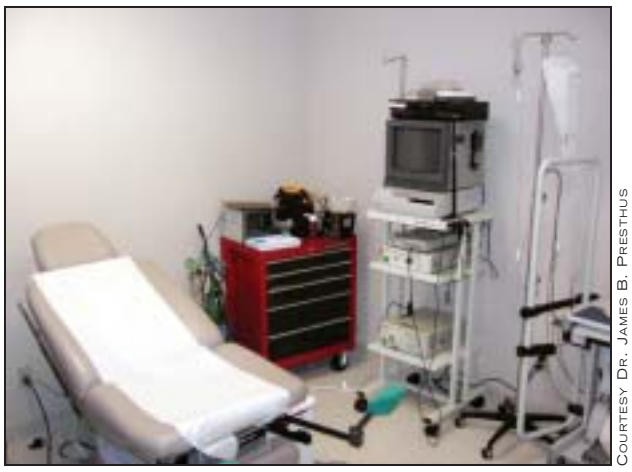
Skills and Set-Up

Ob.gyns. who are performing endometrial biopsies and inserting IUDs are more than capable of doing diagnostic and minor operative hysteroscopy in the office.

The average ob.gyn., in fact, will be competent with the basic hysteroscopic technique for diagnosis after just two to five cases, and the skills honed by doing office diagnostic hysteroscopy will often lay the foundation for adding operative procedures for which there is growing demand, such as hysteroscopic sterilization and global endometrial ablation.

A 2002 survey of women found that sterilization is the most popular method of contraception (favored by 28%), and that women today rarely favor a tubal ligation. Since it has been on the market, the Essure procedure has had successful placement rates of more than 96%.

Hysteroscopic sterilization and global endometrial ablation are both safe and effective for the general ob.gyn. to perform in the office—and just as capably as the best gynecologic surgeon—if he or she is credentialed in the procedure and first has experience and comfort with the procedure in the hospital setting. As a transition, the office setting can be simulated in the OR, with the office staff brought in to observe and prepare for assisting, for instance, and implementing various pain management strategies. The office staff can also learn how to clean and care for the equipment.



COURTESY DR. JAMES B. PRESTHUS

It is not necessary to remodel your office. A normal exam room will almost always suffice for diagnostic and simple operative hysteroscopic procedures.

Many physicians wonder what will happen if they are unable to complete a procedure in the office. Attempts will inevitably sometimes fail because of access problems, patient intolerance, equipment failure, or a complication. But with experience and proper patient selection, this will rarely happen. And if it does—if you're having some difficulty with the ablation set-up, for instance—keep in mind that it is only an office visit, and that the patient can be rescheduled for the operating room.

It is not necessary to remodel your office or have a "procedure room." A normal exam room will almost always suffice for diagnostic and simple operative hysteroscopic procedures. Increasingly, equipment is reasonably priced and companies are able to work with ob.gyns. on favorable leasing arrangements. This has taken away the hurdle of price; in fact, one hysteroscopy procedure a week will pay for the equipment.

The reimbursement issues are also favorable. Office hysteroscopy with biopsy is reimbursed at the same rate in the office as in the OR, and in 2005 global codes were approved for hysteroscopic sterilization and endometrial ablation—another development that makes the investment in hysteroscopy equipment a financially sound decision.

Preparing for office-based procedures takes initiative: Anesthesia guidelines and requirements for facility maintenance must be learned, for instance, and a policy and procedures manual that includes protocols for managing complications must be developed.

There is an unappreciated amount of training support, however—both for technical procedural training and for the range of logistical issues—to be had from experienced colleagues, professional societies, and industry. Ob.gyns. who enjoy procedures are better positioned than ever before to take advantage of it. ■

Several Predictors Cited in Postsurgical Leiomyoma Recurrence

BY MIRIAM E. TUCKER
Senior Writer

WASHINGTON — Subsequent pregnancy and tumor size and number are among the factors that predict whether leiomyomata will recur following myomectomy, Dr. Magdi Hanafi said at the annual meeting of the AAGL.

Myomectomy comprises 33% of all gynecologic surgeries. However, quantitative data on the risk of leiomyoma recurrence following the procedure is largely imprecise, with reported relative risks of anywhere from 5% to 30%.

This wide range is likely explained by differences in the criteria used for recurrence and deficiencies in long-term follow-up, said Dr. Hanafi of St. Joseph's Hospital, Atlanta.

This lack of precision prompted Dr. Hanafi to analyze his own patient population by sending out surveys followed up by phone calls and in-person interviews to 257 patients in whom he had performed abdominal myomectomy between Jan. 1, 1992, and Feb. 28, 2007. "I wanted to get data to give the patient to let her know exactly what to expect," he noted.

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DR. HANAFI

Recurrence was defined as a tumor of 2 cm or larger confirmed by pelvic ultrasound within the last 6 months. Of the 109 patients who responded, 33% (36) reported recurrence of leiomyoma by 10 years. The 5-year cumulative follow-up rate was 24.3%.

Pregnancy following the myomectomy was a significant negative predictor of tumor recurrence, with a recurrence rate of 31% of the 13 women who became pregnant after surgery, compared with 46% of the 96 who did not. However, pregnancy prior to the first myomectomy did not appear to make much difference, with 33% of the 75 women who were pregnant before surgery experiencing tumor recurrence, compared with 32% of the 34 who were not.

Tumor size—determined by pathology report—was also significant in an inverse direction, with the largest tumors (greater than 6 cm) predicting the lowest recurrence rate (17% of 23 women), the smallest ones (2-4 cm) having the highest recurrence (41% of 59), with the medium-sized leiomyomata (4-6 cm) in between (30% of 27).

The number of leiomyomata was similarly significant: Recurrence was 35% among the 100 patients with four or fewer tumors, compared with just 11% of the nine with more than four tumors.

In contrast, neither body mass index nor age significantly predicted leiomyoma recurrence, Dr. Hanafi reported.

He cautioned that while these findings may be helpful in determining the best treatment for women with recurrent fibroids, other factors are also important.

"Factors which have significant impact in leiomyoma recurrence in each patient should be explored according to each patient's medical, social, and emotional status, before a final decision is made for either myomectomy or other treatment options." ■